EXHIBIT 36

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

Artis Ellis	§	
	§	
vs.	§	Civil Action No. 4:14-CV-02126
	§	
Educational Commission for Foreign Medical Graduates	§	
	§	

DIRECT QUESTIONS TO BE PROPOUNDED TO CUSTODIAN OF RECORDS FOR:

SUN LIFE ASSURANCE COMPANY OF CANADA (Disability)

1. Please state your full name, address, telephone number, occupation and official title.
   ANSWER Lawrence R Griffin 1-Sun Life Ex Park Wellesley Ma 02481 781-446-1553
2. I am the custodian for Sun Life
   (Please insert facility or practitioner name.)
3. Have you received a subpoena duces tecum for the production of those documents listed in question number four?
   ANSWER Yes
4. Are you among those who have possession, custody, control of, or access to any and all disability records and/or documents, including but not limited to any and all applications for disability, medical records, requests for leave, requests for accommodation, job descriptions, communications with Artis Ellis, communications with medical providers, documents related to disability payments and/or wage replacement, pertaining to Artis Ellis; D.O.B. [redacted]; SSN: xxx-xx[redacted]; Policy No.: 61296; Policy Holder: Educational Commission for Foreign Medical (ECFMG)?
   ANSWER Yes
5. Were the aforementioned records made in the regular course of business of your employer?
   ANSWER Yes
6. Was it in the regular course of business of the above listed for a person with knowledge of the act, event, condition, opinion, or diagnosis recorded to make the record or to transmit information thereof to be included in such record?
   ANSWER Yes
7. State whether these records were made at the time or shortly after the time of the transactions recorded?
   ANSWER Yes
8. Were these records kept as described in the preceding questions?
   ANSWER Yes
9. Does the source of the information, and the method and circumstance of its preparation, establish the trustworthiness of the records?
   ANSWER Yes
10. Please release exact duplicates of the records as requested in the subpoena duces tecum or the originals thereof for photocopying for attachment to this deposition. Have you done as requested? If not, why not?
    ANSWER Yes
11. Are there any records, documents, papers, correspondence or tangible matters of any kind pertaining to Artis Ellis that you have not provided to the notary public taking your deposition?
    ANSWER NO
12. Please describe all papers, documents, records, correspondence, or tangible matters of any kind that you have not provided to the notary public taking your deposition, and why you have not provided them.
    ANSWER NONE

Ellis
EXHIBIT NO. 32
P. Antone, CRR

13. Are you aware that it may be necessary to subpoena you or your employer to court at the time of the trial of this case, if you have not provided to the notary public taking your deposition all papers, documents, records, correspondence, or tangible matters of any kind pertaining to Artis Ellis?
ANSWER Yes

Laura R Griffin
WITNESS (Custodian of Records)

Before me, the undersigned authority, on this day personally appeared 3-10-16 Lawrence R Griffin, custodian of records for the above listed, known to me to be the person whose name is subscribed to the foregoing instrument in the capacity therein stated, who being first duly sworn, stated upon his/her oath that the answers to the foregoing questions are true and correct. I further certify that the records attached hereto are exact duplicates of the original records.

SWORN TO AND SUBSCRIBED before me this 10th day of March, 20 16.

NOTARY PUBLIC

ANNA SANTOS
Notary Public
COMMONWEALTH OF MASSACHUSETTS
My Commission Expires
March 28, 2019

Sun Life Financial®

Employee Benefits Group

175 Addison Road
Windsor, CT 06095
Tel: 860.737.1000
FAX: 860.737.1093
www.sunlife.com

GENWORTH FINANCIAL IS NOW
SUN LIFE FINANCIAL

To: Jennifer Burns
US Legal Support

From: Barbara Kinney
Tel #: 860-737-6671
Fax #: 860-737-6598
Date: March 9, 2016

Fax: 281-552-8944

This cover + 19 page(s)

Message:

Re: Artis Ellis Records

- ○ Original will follow by mail
- ● No other copy will be sent.
- ○ Please make copies and distribute

Print

Claim Control #	Claim Status	Claim Type
Policy #	Client #	Group Office
Last Name	First Name	Claim Office
Last Payment Date		
Start Date	Due Date	Priority

D-MAP

Claim Control # 041012-02281-00

03/02/2016 4:41:11 PM Norma Charles - FE

PRINTED FILE AS REQUESTED

03/01/2016 7:58:39 AM Larry Griffin - FE

sent to request to have file printed
E-mail from Legal

From: Barbara J Kinney/Legal/US/SunLife
To: Larry Griffin/Group/US/SunLife@SunLife, Cynthia Johnston/Group/US/SunLife@SunLife, Yarimal Lara/Group/US/SunLife@SunLife, Susan Krute/Group/US/SunLife@SunLife, Kim McCraw/Group/US/SunLife@SunLife, Layna Koy/Group/US/SunLife@SunLife
Date: 02/29/2016 01:49 PM
Subject: Subpoena Notice - Ellis

Your Response is Manditory and Required Immediately

Subpoena Notice

Group Document Request

We have received a subpoena request for the following information listed below, please provide the documents checked below by;
Due Date: Immediately

Client Name: Artis Ellis SSN/TIN: [redacted]
DOB: [redacted]
Policy #: 61296 Claim #

Documents Requested

	Beneficiary Forms (designation/change)
	Benefit Payment Documentation
	Changes of Ownership
X	Claim File
	Copies of Benefit Checks
	Copy of Policy
X	Correspondence
X	Applications for benefits
X	Medical Records
X	Payment History
	Premium Payment documentation
	Surveillance Reports
	Current Status of policy

Additional Items Requested

	Video CDs
	Photographs

Please let me know if you are able to establish a relationship. If a relationship exists, please pull the requested documentation and forward to my attention by the date above at SC 5500 / W499 (Windsor 4th Floor)

Barbara J. Kinney
Sun Life Financial
Law Department
175 Addison Road
Windsor, CT 06095
Tel: 860-737-6671
Fax: 860-737-6598
barbara.kinney@sunlife.com

02/25/2016 10:35:10 AM Kaitlyn Nickle - CSC

Jennifer Justiss called to see where she could submit request to subpoena all EEs docs. Gave email, fax # and mailing address.

10/15/2012 10:16:13 AM Victoria Strout - MSTD

$1200 Report/ok vls

10/12/2012 8:53:07 AM Andrea Bayides - STDA

$1200 Audit/OK/AB

10/11/2012 1:56:36 PM Maura Harnois - STDA

From: Maura Harnois/Group/US/SunLife
To: STD QA@SunLife
Date: 2012/10/11 01:55 PM
Subject: Approved: 1.2K - Artis Ellis 041012-02281-00

Approved: 1.2K - Artis Ellis 041012-02281-00

Maura Harnois
Claims Associate, Short Term Disability
Sun Life Financial Employee Benefits Group
Phone 1-800-451-2513 EXT 1188
Fax (781) 304-5519

10/11/2012 1:51:26 PM Maura Harnois - STDA

From: Maura Harnois/Group/US/SunLife
To: jplush@ecfmg.org
Date: 2012/10/11 01:49 PM
Subject: Advice to Pay: Artis Ellis

Hello,

Attached you will find a SunAdvisor disability claim recommendation for the above referenced employee based upon a review of all information in our files. Disability payments, if due, are mailed the business day following claim approval and will continue weekly through the Approved To date.

Should you not accept this claim recommendation for any reason, please respond to this email within 24 business hours. Should you have any questions regarding this claim or your STD plan, please feel free to contact me directly at any time.

[attachment "Artis Ellis ATP.doc" deleted by Maura Harnois/Group/US/SunLife]

Maura Harnois
Claims Associate, Short Term Disability
Sun Life Financial Employee Benefits Group
Phone 1-800-451-2513 EXT 1188
Fax (781) 304-5519

10/11/2012 1:43:23 PM Maura Harnois - STDA

Occ: Center Mgr, light occ, no JD rec'd
LDW: 9/11/2012
DX: 227.3; pituitary macrodenima
TD date 9/12/2012
Expiry: 12/9/2012
LTD eligible: Y
MDA info: 227.3: Benign Neoplasm of Other Endocrine Glands and Related Structures; Pituitary Gland and Craniopharyngeal Duct; Craniobuccal Pouch; Hypophysis; Rathke's Pouch; Sella Turcica, duration not listed
Special Instructions: Plan 80
EARNINGS DEFINITION - USE SUN LIFE STANDARD
15TH OF THE MONTH FOLLOWING 3 MONTHS OF EMPLOYMENT
W-2 SERVICE ADDED EFFECTIVE TAX YEAR 2005
PHILADELPHIA
PRIOR COVERAGE

**********SUN ADVISOR ADMINISTRATIVE SERVICES ONLY*****
****
DEFINITION OF DISABILITY - USE PRIOR DEFINITION OF DISABILITY
State Dis?: no
STD Contrib: NC
Contribution/taxability in CHESS match ER section?: n/a
BA: Joseph Plush [redacted]
AP: Dr. Yorshon 713-798-4696
Mail Code: E001
Initial claim decision:

I have rev'd the contract for eligibility wording, doh, wp, and contributions - EE appears eligible for STD coverage. I have reviewed Ultera for prior STD and LTD claims- this new claim is not successive. I have verified no outstanding overpayments

$1677.12 weekly earnings
EE rec'd sick pay 9/12 – 9/25/12, $1677.12, set offset in CHESS.

EE experiencing dizziness, HO confined 9/12 -9/15/12, EE underwent SX for resection of pituitary adenoma on 9/14/12, R&Ls; patient should stay off work 4 – 6 weeks to allow complete recovery. Severe limitation.
AP: RTW 10/22/2012

Reasonable to ATP to 10/21/12, closed claim, sent ATP
Called EE [redacted], phone rang, no VM picked up
Sent to 1.2 K Audit

Sun Life Assurance Company of Canada
Short Term Disability Claim Packet

Sun Life Financial

Instructions for the Plan Administrator

An initial claim for Short Term Disability benefits should be submitted when a disability absence has actually begun, and it first appears that the eligible employee's disability will extend beyond the required elimination period. To file a Short Term Disability Claim, prefill Section A: Employer's Statement. Then, provide the entire claim packet to the employee. The employee should make sure all of the sections are complete including the Physician Statement. Then, he or she should mail or fax the completed claim form to:

Sun Life Assurance Company of Canada
Group Short Term Disability Claims
P.O. Box 81015
Wellesley Hills, MA 02481
Tel: 1-800-242-6875
Fax: (781) 304-3599

Failure to provide complete and accurate information could result in the need for additional claims investigation which could delay the initial benefit payment.

Section A: Employer's Statement

1 General Information

Please print clearly.

Name of employer		Group policy number	Class
ECFMG		61296	
Name of employee (first, middle initial, last)	☐ M ☑ F	**Social Security number**	**Date of birth**
Artis Ellis		[redacted]	[redacted]
Name and address of Division where employee works			**Employee phone no.**
400 N. Sam Houston Pkwy East Houston, TX			

2 Employment and Claim Information

Be sure to include all salary information.

Date hired (m/d/y)	Effective date of insurance	Date last worked	Hours worked last day
4/8/05	7/1/05	9/11/12	7

Job title / Major job duties (Or, attach employee's formal job description)
Center Mgr. - All functions of running a testing center

Regularly scheduled work week:	How long had employee been in occupation?
Days per week: 5 Hours per day: 7	Years: 4 Months: 9
Has the employee's employment been terminated? ☐ Yes ☑ No	If yes, provide termination date
Why did employee cease working? Disability	

2 Employment and Claim Information continued

How would you classify this employee's occupation?
☐ Sedentary (1-10 lbs) ☒ Light (11-20 lbs) ☐ Medium (21-50 lbs) ☐ Heavy (51+ lbs)

Is the condition due to an injury or sickness arising out of employee's job? ☐ Yes ☒ No ☐ Disputed

Has a Workers' Compensation claim been filed? ☐ Yes ☒ No

If "yes," please include the initial report of illness/injury and award/denial notice with this claim

Name of your Workers' Compensation carrier:	Phone number
Has employee returned to work? ☐ Yes ☐ No If yes: ☐ With restrictions ☐ Full capacity	Date returned

3 Salary and benefits information

Indicate whether or not the employee contributes to the STD premium on a pre- or post-tax basis.

How was the employee paid? (check one)

☐ Hourly	☒ Salaried
$ per hour	$ per week 1677.12

Provide information about other income:

Commissions	Bonuses	Overtime
$	$	$

Does employee contribute toward the STD premium? ☐ Yes ☒ No

- If "yes," attach a copy of employee's enrollment form to this claim and indicate percentage contribution ..... Employee: % Employer: %
- Are employee contributions made with pre-tax dollars? ☐ Yes ☐ No

4 Information About Other Income

Is employee currently receiving, or entitled to receive, benefits from any of the following sources?

Check all that apply and provide details for each source of income.

Source of Income	Amount of each payment	Weekly or monthly?	Period/date(s) covered by payment
☐ Vacation pay	$	☐ Wkly ☐ Mnly	
☒ Sick pay	$ 1677.12	☒ Wkly ☐ Mnly	9/12 - 9/25
☐ State Disability	$	☐ Wkly ☐ Mnly	
☐ Other:	$	☐ Wkly ☐ Mnly	

5 Certification and Signature

Tip: To certify eligibility, mail or fax the employee's enrollment form with the claim.

I certify that the above statements are true and complete. I have read and understand the Fraud Warning on page 6 of this packet.

Name of person completing this form	Telephone number	E-mail address
Joseph Fust	[redacted]	joe.fust@ecfmg.org
Signature	Title	Date signed
X [signature]	Benefits Training Mgr	10/3/12

For more information about Short Term Disability, the claim process and the status of your employees' claims, log onto CustomerLink at https://customerlink.sunlife-usa.com

Sun Life Assurance Company of Canada

Short Term Disability Claim Packet

Sun Life Financial

Section B: Employee's Statement

1 General Information

Provide your full address and Social Security number.

Please print clearly

Your name (first, middle initial, last)	☐ M ☑ F	Social Security number	Date of birth
Artis Ellis		[redacted]	[redacted]
Your street address [redacted]	City [redacted]	State	Zip Code
Your occupation: Center manager		Telephone Number: (281) 265-7400 x226	
Employer Name: ECFMG		Group Policy Number: 61296	

2 Information About the Condition Causing Your Disability

Reminder: Return completed claim packet (including Attending Physician Statement) and all required documentation to:

Sun Life Assurance Company of Canada
Group STD Claims
P.O. Box 81915
Wellesley Hills, MA 02481
Tel: 1 800 247 8878
Fax: (781) 304-5599

Type (check one): ☐ Pregnancy ☐ Motor vehicle accident ☐ Work-related injury/sickness ☑ Sickness ☐ Other accident

Describe in detail how, when and where the accident occurred –OR– Describe the nature of your illness/condition and its first symptoms. If work-related, describe cause of injury/illness.
Major brain tumor remove from the brain

Date you were first treated by a physician	Last day worked prior to disability	Did you work a full day?
9/11/12	9/12/12	☐ Yes ☐ No

Name of your first treating physician	Physician phone number
Dr Dos Santos	(713) 798-4696

Hospital	Hospital phone number	Date(s) of admittance
St Luke's	(832) 355-2171 (713) 798-4696	9/12 - 9/15

Date first unable to work	Date you expect to return to work	Do you expect to return full- or part-time?
9/12/12	10/22/12	☑ Full-Time ☐ Part-Time

If work-related, have you filed/do you intend to file, a Workers' Compensation claim?... ☐ Yes ☑ No

3 Information About Other Income

Check all that apply and provide details for each source of income.

Are you currently receiving, or entitled to receive, benefits from any of the following sources?

Source of Income	Amount of each payment	Weekly or monthly?	Period/date(s) covered by payment
☐ Vacation pay	$	☐ Wkly ☐ Mthly	
☑ Sick pay	$ 2	☑ Wkly ☐ Mthly	
☐ State Disability	$	☐ Wkly ☐ Mthly	
☐ Other:	$	☐ Wkly ☐ Mthly	

4 Signature

Reminder: Please be sure to sign and return any Authorization statements included in this packet.

I certify that the above statements are true and complete. I have read and understand the Fraud Warning on page 6 of this packet.

Employee's signature	Date signed
x Artis Ellis	10/2/12

Sun Life Assurance Company of Canada

Short Term Disability Claim Packet

Sun Life Financial

Section C: Attending Physician's Statement

1 Information About the Patient

The patient is responsible for any costs associated with the completion of this form.

Please print clearly

Name of Patient (first, middle initial, last) ☐ M ☒ F: Artis Ellis
Social Security number: [redacted]
Date of birth (m/d/y): [redacted]
Name of Employer: ECFMG
Group Policy number: 61296
Employee phone no.:

2 Diagnosis and History

Provide general information about diagnosis and history in this section. Then, please elaborate in section(s) 3 – 6 as appropriate.

Diagnosis including any complications and ICD-9 Codes(s): pituitary macroadenoma ICD 9 : 227.3
Objective findings (i.e. x-rays, EKGs, MRIs, laboratory data and any other clinical findings): MRI with pituitary macroadenoma
Subjective Symptoms: patient with vision loss and headaches
Date symptoms first appeared or date of accident: August 30, 2012
Date Disability Commenced: 9/12/12
Has patient ever had same or similar condition? ..... ☐ Yes ☐ No If Yes, when: Unknown
Is condition due to injury/sickness arising out of patient's employment? ... ☐ Yes ☒ No ☐ Unknown
Names and telephone numbers of Other Treating Physicians (if applicable) ...
If pregnancy, please provide the following information: N/A
• Expected delivery date: _____ • Actual delivery date: _____ • C-Section? ☐ Yes ☐ No
Describe any complications that would extend this disability longer than a normal pregnancy

3 Treatment

Include in description any surgery, therapeutic modalities, psychological intervention and medications prescribed.

Patient first visit: 9/12/12
Date of last visit: 9/25/12
Date of next visit: 9/25/12
Frequency of treatment ..... ☐ Weekly ☐ Monthly ☒ Other (please specify): in 2 months
Description of Treatment: Patient underwent surgery for resection of pituitary adenoma on 9/14/12

4 Progress

Has patient: ..... ☒ Recovered ☐ Unchanged ☐ Improved ☐ Retrogressed
Is patient: ..... ☐ Ambulatory ☐ Bed confined ☐ House confined ☐ Hospital confined
If unchanged or retrogressed, please explain:
Has patient been hospital confined? ..... ☒ Yes ☐ No From: 9/12/12 To: 9/15/12
If yes, provide name and address of hospital: St. Luke's Episcopal Hospital, Houston, TX 77030

Continued on next page

Sun Life Assurance Company of Canada

Sun Life Financial™

Short Term Disability Claim Packet

Section C: Attending Physician's Statement

1 Information About the Patient

Please print clearly

The patient is responsible for any costs associated with the completion of this form.

Name of Patient (first, middle initial, last)	☐ M ☐ F	Social Security number	Date of birth (m/d/y)
Artis Ellis		[redacted]	[redacted]
Name of Employer		Group Policy number	Employee phone no.
ECFMG			

2 Diagnosis and History

Provide general information about diagnosis and history in this section. Then, please elaborate in section(s) 3–6 as appropriate.

Diagnosis including any complications and ICD-9 Codes(s) ICD 9 : 227.3

pituitary macroadenoma

Objective findings (i.e. x-rays, EKGs, MRIs, laboratory data and any other clinical findings)

MRI with pituitary macroadenoma

Subjective Symptoms

patient with vision loss and headaches

Date symptoms first appeared or date of accident	Date Disability Commenced
August 30, 2012	9/12/12

Has patient ever had same or similar condition? ..... ☐ Yes ☐ No If Yes, when: Unknown

Is condition due to injury/sickness arising out of patient's employment? ..... ☐ Yes ☒ No ☐ Unknown

Names and telephone numbers of Other Treating Physicians (if applicable) N/A

If pregnancy, please provide the following information: N/A

• Expected delivery date: _____ • Actual delivery date: _____ • C-Section? ☐ Yes ☐ No

Describe any complications that would extend this disability longer than a normal pregnancy

3 Treatment

Include in description any surgery, therapeutic modalities, psychological intervention and medications prescribed.

Date of first visit	Date of last visit	Date of last examination
9/12/12	9/25/12	9/25/12

Frequency of treatment ..... ☐ Weekly ☐ Monthly ☒ Other (please specify: q 3 months)

Description of Treatment

Patient underwent surgery for resection of pituitary adenoma

4 Progress

Has patient: ..... ☒ Recovered ☐ Unchanged ☐ Improved ☐ Retrogressed

Is patient: ..... ☐ Ambulatory ☐ Bed confined ☐ House confined ☐ Hospital confined

If unchanged or retrogressed, please explain:

Has patient been hospital confined? ..... ☒ Yes ☐ No From: 9/12/12 To: 9/25/12

If yes, provide name and address of hospital

St. Luke's Episcopal Hospital, Houston, TX 77030

Continued on next page

5 Restrictions and Limitations

Restrictions and Limitations should be associated with the Objective and Subjective findings/symptoms noted in section 2.

Restrictions (what the patient should not do): Patient should stay off work 4-6 weeks to allow complete recovery

Limitations (what the patient cannot do):

Is the patient capable of working within these restrictions/limitations? ☐ Yes ☒ No

Can the patient work an eight-hour day with these restrictions/limitations? ☐ Yes ☒ No

If no, how many hours could he/she work? Not working ____ Hours

Is patient capable of working in another occupation? ☐ Yes - Full-time ☐ Yes - Part-time ☒ No

Indicate class of physical impairment.

* As defined in federal dictionary of occupation titles

Physical Impairment

- ☐ Class 1 – No limitation of functional capacity; capable of heavy work* No restrictions (0-10%)
- ☐ Class 2 – Medium manual activity* (15-30%)
- ☐ Class 3 – Slight limitation; capable of light work* (35-65%)
- ☐ Class 4 – Moderate limitation; capable of clerical/administrative (sedentary*) activity (60-70%)
- ☒ Class 5 – Severe limitation; incapable of minimum (sedentary*) activity (75-100%)

Indicate class of mental impairment.

Mental Impairment (if applicable)

- ☐ Class 1 – No limitation
- ☒ Class 2 – Slight limitation
- ☐ Class 3 – Moderate limitation
- ☐ Class 4 – Marked limitation
- ☐ Class 5 – Severe limitation

What is the patient's current DSM-IV-R diagnosis?

Axis I: ____ Axis IV: ____

Axis II: ____ Axis V: ____

Axis III: ____

Do you believe this patient is competent to endorse checks/direct the use of proceeds? ☒ Yes ☐ No

6 Return-to-Work

1. When will patient recover sufficiently to perform duties? (Specify date or check recovery period)
   - Patient's occupation part-time: Date ____ or ☐ < 3 wks ☐ 3-4 wks ☐ 5-6 wks ☐ 7-8 wks ☐ 2 months or more ☐ Never
   - Patient's occupation full-time: Date 10/22/12 or ☐ < 3 wks ☐ 3-4 wks ☒ 5-6 wks ☐ 7-8 wks ☐ 2 months or more ☐ Never
2. After reviewing the material and substantial duties of the patient's occupation, would you recommend vocational counseling and/or rehabilitation or job modification? ☐ Yes ☒ No

7 Certification and Signature

Remember to provide your full address and Tax ID number.

A stamp or signature of a person other than the examining physician is not acceptable.

I certify that the above statements are true and complete. I have read and understand the Fraud Warning on page 6 of this packet.

Name of Attending Physician	Degree/Specialty	
Daniel Yoshor	MD	
Street address: 1709 Dryden	City: Houston	State: TX Zip code: 77030
Tax ID number: 74-1013878	Telephone number: (713) 798 4696	Fax number: (713) 798 3739
Attending Physician Signature: X		Date: 9/25/12

Sun Life Assurance Company of Canada

Short Term Disability Claim Packet

Sun Life Financial™

Fraud Warnings

State law requires that we notify you of the following:

Fraud Warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Fraud Warning - California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Fraud Warning - Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Fraud Warning - Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Fraud Warning - Louisiana and Massachusetts: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Fraud Warning - Maryland: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime as determined by a court of competent jurisdiction.

Fraud Warning - New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Fraud Warning - Oregon, Virginia and Washington: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Fraud Warning - Vermont: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and subjects such person to criminal and civil penalties.

Sun Life Assurance Company of Canada

Sun Life Financial™

Authorization for Release and Disclosure of Health Related Information

This Authorization complies with the HIPAA Privacy Rule. It is important for you to read, sign and submit all Authorizations in this packet. Failure to submit all Authorizations could result in a delay during the claims process.

Return to:
Sun Life Assurance Company of Canada
Group STD Claims
P.O. Box 81915
Wellesley Hills, MA 02481
Fax: (781) 304-5509

I HEREBY AUTHORIZE any physician, health care provider, health plan, medical professional, hospital, clinic, laboratory, pharmacy or other medical or healthcare facility that has provided payment, treatment or services to me or on my behalf, to disclose my entire medical record and any other protected health information concerning me to the Claims Department of Sun Life Assurance Company of Canada ("the Company") its subsidiaries, affiliates, third party administrators and reinsurers.

I understand that such information may include records relating to my physical or mental condition such as diagnostic tests, physical examination notes and treatment histories, which may include information regarding the diagnosis and treatment of human immunodeficiency virus (HIV) infection, sexually transmitted diseases, mental illness and the use of alcohol, drugs and tobacco, but shall not include psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization, and I instruct any physician, health care professional, hospital, clinic, medical facility or other health care provider to release and disclose my entire medical record without restriction.

I understand that the Company will use the information it obtains to (a) administer claims; (b) determine or fulfill responsibility for coverage and provision of benefits; (c) administer coverage; and/or (d) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company.

I understand that the Company will not disclose information it obtains about me except as authorized by this Authorization; as may be required or permitted by law; or as I may further authorize. I understand that if information is redisclosed as permitted by this Authorization, it may no longer be protected by applicable federal privacy law.

I understand that: (a) this Authorization shall be valid for 24 months from the date I sign it; (b) I may revoke it at any time by providing written notice to Sun Life Financial, Group Short Term Disability Claims, SC 3212, One Sun Life Executive Park, Wellesley Hills, Massachusetts, 02481, subject to the rights of any person who acted in reliance on it prior to receiving notice of its revocation; and (c) my authorized representative and I are entitled to receive a copy of the Authorization upon request.

A copy of this Authorization shall be as valid as the original.

Print Name of Employee or Personal Representative of Employee	Group Policy Number
If Representative, description of your authority or relationship to employee	
Signature of Employee or Personal Representative X [signature]	Date 10/2/12

Sun Life Assurance Company of Canada

Sun Life Financial

Authorization for Release and Disclosure of Psychotherapy Notes

This Authorization complies with the HIPAA Privacy Rule. It is important for you to read, sign and submit all Authorizations in this packet. Failure to submit all Authorizations could result in a delay during the claims process.

Return to:
Sun Life Assurance Company of Canada
Group STD Claims
P.O. Box 81915
Wellesley Hills, MA 02481
Fax: (781) 304-5599

I HEREBY AUTHORIZE any: physician, health care provider, health plan, medical professional, hospital, clinic, or other medical or health care facility that has provided payment, treatment or services to me or on my behalf; to disclose any psychotherapy notes relating to me to the Claims Department of Sun Life Assurance Company of Canada ("the Company") its subsidiaries, affiliates, third party administrators and reinsurers.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization, and I instruct any physician, health care professional, hospital, clinic, medical facility or other health care provider to release and disclose all psychotherapy notes relating to me without restriction.

I understand that the Company will use the information it obtains to: (a) administer claims; (b) determine or fulfill responsibility for coverage and provision of benefits; (c) administer coverage; and/or (d) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company.

I understand that the Company will not disclose information it obtains about me except as authorized by this Authorization; as may be required or permitted by law; or as I may further authorize. I understand that if information is redisclosed as permitted by this Authorization, it may no longer be protected by applicable federal privacy law.

I understand that: (a) this Authorization shall be valid for 24 months from the date I sign it; (b) I may revoke it at any time by providing written notice to Sun Life Financial Group Short Term Disability Claims Department, SC3212, One Sun Life Executive Park, Wellesley Hills, Massachusetts, 02481, subject to the rights of any person who acted in reliance on it prior to receiving notice of its revocation; and (c) my authorized representative and I are entitled to receive a copy of the Authorization upon request.

A copy of this Authorization shall be as valid as the original.

Print Name of Employee or Personal Representative of Employee	Group Policy Number
If Representative, description of your authority or relationship to employee	
Signature of Employee or Personal Representative X Orita Ellis	Date 10/2/12

Sun Life Assurance Company of Canada
Wellesley Hills, MA 02481
1-800-247-6975

Sun Life Financial™

PRIVACY INFORMATION NOTICE

This notice explains why Sun Life Assurance Company of Canada ("the Company") collects personal information about you, how we use that information, and under what circumstances we disclose it to others.

[illegible]
We need to obtain information about you to determine whether we can provide the insurance benefits you have requested. As part of the claims process, we may ask you to undergo a physical examination, submit a statement from your physician, or provide copies of medical tests or other information relating to your health, finances and activities.

We also may collect information about you from other sources. By signing the Authorization For Release And Disclosure of Health Related Information and/or the Authorization For Release And Disclosure of Psychotherapy Notes, you authorize us to obtain medical information about you that we need to underwrite your application. Depending upon your particular circumstances, we may collect additional information about you from the following sources:

- Physicians, health care providers, medical professionals, hospitals, clinics or other medical or health care related facilities
- Other insurance companies you have applied to for insurance
- Public records, such as Social Security and tax records

DISCLOSURE OF PERSONAL INFORMATION

When you sign the Authorization For Release And Disclosure of Health Related Information and/or the Authorization For Release And Disclosure of Psychotherapy Notes, you authorize us to disclose information we have about you:

- To our reinsurers
- As required or permitted by law

In the course of the claims process, we may need to disclose information about you to others. The law permits us to disclose such information, without obtaining authorization from you, to:

- Companies that help us conduct our business or perform services on our behalf
- Your physician or treating medical professional
- Comply with federal, state or local laws, respond to a subpoena or comply with an inquiry by a government agency or regulator

ACCESS, CORRECTION AND AMENDMENT OF PERSONAL INFORMATION

Upon written request to the Company, you can:

- Obtain a copy of the personal recorded information we have about you in our files (a fee may be charged to cover the cost of providing a copy of such information)
- Request that we correct, amend or delete any recorded personal information about you in our possession
- File your own statement of facts if you believe that the recorded personal information we have about you is incorrect

To take any of these actions, please contact us at the following address for further instructions:

Sun Life Assurance Company of Canada
Group Short Term Disability Claims
P.O. Box 81703
Wellesley Hills, MA 02481

Sun
Life Financial

Service Agreement: 61296

SunAdvisor® Short Term Disability

Date:	Thursday, October 11, 2012	From:	Maura Hamois
To:	Joe Plush	Email:	jplush@ecfmg.org
Company:	Educ Com for Foreign Med Grads	Pages:	1
Re:	SICK LEAVE ADVICE NOTIFICATION 041012-02281-00		

We have completed our review of your request for advice regarding the following employee's absence.

Employee: Artis Ellis **Employee I.D. #** [redacted]

According to our review of the information received, we recommend that the disability approval commence effective **September 12, 2012 (date of hospitalization).** Any payment would be subject to your plan elimination period for an illness. At this time we recommend, based on the employee's condition, that the disability payment continue through **October 21, 2012 (one day prior to the physician's return to work date).**

If the employee does not return to work on a full-time basis by the aforementioned date, and would like to be considered for additional benefit review, a medical update should be submitted. **Specifically**, the employee should have the treating physician submit a copy of the examination report(s) and any accompanying test results. This information may be forwarded to this office by fax at **(781) 304-5519** or mailed to the above address. Upon receipt, we will advise you accordingly. **Please note: An out of work note is generally not effective in detailing evidence of ongoing disability.**

Should you have any questions or concerns, or if you require assistance obtaining information or otherwise, please feel free to call our Customer Service Department at (800)247-6875.

Sincerely,

Maura Hamois, *SunAdvisor®*

SUN ADVISOR/ ECI ELIGIBILITY REVIEW

Work Type
SunAdvisor Eligibility

Claim Control #:	Claim Status:	Claim Type:
041012-02281-00	Potential	Sun Advisor
Policy #:	Cert #:	Group Office:
61296	458539208	
Last Name:	First Name:	Claim Office:
ELLIS	ARTIS	Portsmouth
Last Payment Date:		
Start Date:	Due Date:	Priority:
5/Oct/2012	5/Oct/2012	1

ELIGIBILITY REVIEW

Mod#:	4		
Elim Period Accident:		Elim Period Illness:	
1st Day Hospital:			
# of Weeks In Plan:		Eligible for LTD:	
Has EE RTW:		If Y, Date:	
Employment Status:			
Primary Diagnosis:		Age:	
Secondary Diagnosis:			
Treatment Plan			
ICD Code(s):			
Disability Advisor Page #:		Date Last Worked:	11/Sep/2012
Doctor's Dis Date:	12/Sep/2012	Date 1st Treat after DLW:	
Date of Last OV:		Date Hospitalized:	12/Sep/2012

Work Related ***If Not Answered Call***
Employer:
__ Completed Phone Template
Physician:
__ Completed Phone Template

Assigned To:	Created:	Work Item ID:
Maura Harnois - STDA	5/Oct/2012	7885850

ZSYS Chess Task

Work Type
ZSYS - AM Sent Task

Claim Control #:	Claim Status:	Claim Type:
041012-02281-00	Terminated	Sun Advisor
Policy #:	Cert #:	Group Office:
61296	458539208	PHILADELPHIA
Last Name:	First Name:	Claim Office:
ELLIS	ARTIS	Boston
Last Payment Date:		
21/Oct/2012		
Start Date:	Due Date:	Priority:
12/Oct/2012	12/Oct/2012	1

Description:
Message:

* IMPORTANT We were pleased to learn that you returned to work on 221012. This payment represents the final benefit payment as of October 21, 2012. Your claim file is now closed. Thank you.

Assigned To:	Created:	Work Item ID:
	12/Oct/2012	7907082

TEAM LEAD/MANAGER REFERRAL

Work Type
Team Lead / Manager Referral

Claim Control #:	Claim Status:	Claim Type:
041012-02281-00	Terminated	Sun Advisor
Policy #:	Cert #:	Group Office:
61296	458539208	PHILADELPHIA
Last Name:	First Name:	Claim Office:
ELLIS	ARTIS	Boston
Last Payment Date:		
21/Oct/2012		
Start Date:	Due Date:	Priority:
12/Oct/2012	19/Oct/2012	3

REFERRAL

__ Complaint received dated: From
__ See Second Appeal Dated:
and Medical Opinion Dated:
__ See correspondence dated: From
__ Cheque over authority level:
__ See File Summary/D-MAP:
__ Handle Approval
__ Provide Recommendation
__ See Comments
QC-Clear-AB

RESPONSE

Team Leader/Manager Response:
__ Agree with action plan
__ See Comments/Recommendations
__ See Comments

Assigned To:	Created:	Work Item ID:
Andrea Bayides - STDA	12/Oct/2012	7907752

ZSYS Chess Task

Work Type
ZSYS - AM Sent Task

Claim Control #:	Claim Status:	Claim Type:
041012-02281-00	Terminated	Sun Advisor
Policy #:	Cert #:	Group Office:
61296	458539208	PHILADELPHIA
Last Name:	First Name:	Claim Office:
ELLIS	ARTIS	Boston
Last Payment Date:		
21/Oct/2012		
Start Date:	Due Date:	Priority:
17/Oct/2012	17/Oct/2012	1

Description:
Message:

" IMPORTANT We were pleased to learn that you returned to work on 221012. This payment represents the final benefit payment as of October 21, 2012. Your claim file is now closed. Thank you.

Assigned To:	Created:	Work Item ID:
	17/Oct/2012	7921721